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KENTUCKY BOARD OF NURSING
312 Whittington Parkway, Suite 300
Louisville, Kentucky 40222-5172
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Steven L. Beshear
Governor

Medication Report

Participant Name: _____

License Number: _____ Social Security Number: _____

☐ KARE for Nurses Program
☐ Probation

I understand that I must report the use of all medications to my Case Manager. This report must include all prescription medications as well as all over-the-counter (OTC) medications, vitamins and herbal preparations. Notification to the Case Manager is to occur prior to the initiation of any medication. The following is a list of all medications and preparations that I am currently using, and all medications that I use on a prn basis.

Medication	Dose	Refills	Start Date	End Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____   _____
Signature of Participant   **Date**

9/14/2006
jmc